**Oregon Health & Science University**
Joseph B. Totman Health & Wellness Center
**IMMUNE STATUS FORM**

Mail, Email or Fax to:
JBT Health & Wellness Center, L.587
3181 SW Sam Jackson Park Road
Portland, OR 97239-3098
FAX: 503.494.2958
askjbhealth@ohsu.edu

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**REQUIRED IMMUNIZATIONS** - Dates must include MM/DD/YYYY if available. **Incomplete forms will incur a $95 fee.**

1) **TETANUS/DIPHTHERIA**  
   **Required:** 1. Primary series of 3.  
   **Required:** 2. TDAP Booster within the last 10 years.  
   Date completed: __________  
   Date: __________

2) **POLIO**  
   **Required:** Primary series of 4. Date of completion __________  
   Date of adult booster (or #5) if received __________

3) **MEASLES** (Rubella)  
   **Required:** One of the following  
   1) Immunity confirmed by blood titer *(Attach copy of lab report)*  
      Date of titer: __________
   or  
   2) Two MMR vaccinations  
      #1 __________  
      #2 __________

4) **MUMPS**  
   **Required:** One of the following  
   1) Immunity confirmed by titer *(Attach copy of lab report)*  
      Date of titer: __________
   or  
   2) Two MMR vaccinations  
      #1 __________  
      #2 __________

5) **RUBELLA**  
   **Required:** One of the following:  
   1) Immunity confirmed by blood titer *(Attach copy of lab report)*  
      Date: __________
   or  
   2) Two MMR vaccinations  
      #1 __________  
      #2 __________

6) **HEPATITIS B**  
   **Required:** 3 doses and positive titer *(Titer required for all with blood or body fluid exposure. If no patient or animal exposure vaccine required but titer not needed)*  
   Dose #1 __________  
   Dose #2 __________  
   Dose #3 __________

   HepB surface antibody titer to prove immunity *(Attach copy of lab report)*  
   Date __________

   Additional vaccinations may be needed if titer is negative.

7) **VARICELLA**  
   **Required:** One of the following:  
   1) Documentation of two doses of varicella vaccine  
      Date #1: __________  
      Date #2: __________  
   or  
   2) Laboratory evidence of immunity *(varicella antibody titer)*  
      Date __________  
      Result __________  
      *(Attach copy of lab report)*

8) **TUBERCULIN STATUS**  
   **Note:** You will also need annual TB test (TST) clearance while at OHSU.  
   List dates for two-step TST, two tests, both negative, at least a week but not more than a year apart, the second must be done less than 12 months before entry to OHSU.  
   **Required:** 1) Skin Test #1: Date: __________  
   Result: Neg____  
   Pos____  
   mm if known ________  
   2) Skin Test #2: Date: __________  
   Result: Neg____  
   Pos____  
   mm if known ________  
   or  
   Quantiferon TB Gold blood test: Date ________  
   If you have a positive TST, submit a chest x-ray report within last year and INH history. If you had BCG, please obtain a Quantiferon TB Gold test and submit the result.